HEALTH INSURANCE COVERAGE WAIVER
FOR
FULL-TIME STAFF AND FACULTY

_____ _____

Employee Name (Last, First, Middle Initial) *Banner ID*

_____

Campus or Department

I, hereby, waive all medical plan benefits under the programs sponsored by Saint Louis University for myself and any eligible dependents, effective as of _____. I understand that this waiver voids coverage that I might otherwise receive free of charge from the University or for which there may only be nominal payroll deduction cost to me.

In executing this waiver, I understand that neither I, nor any of my eligible dependents, may re-enroll in a Saint Louis University medical plan except under the terms and conditions described in the Summary of Benefits for a University sponsored plan and the provisions of the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____

Employee Signature *Date*

Do not write below this line

_____ _____

Benefits Representative Signature Effective Payroll Date